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**The situation of transgender people in Japan**

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### **Resum del TFG**

Revisió per via legislativa, mèdica i dels drets humans de la situació de les persones transgènere al Japó.

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### **Resumen del TFG**

Revisión por vía legislativa, médica y de derechos humanos de la situación de las personas transgénero en Japón.

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Transgender, LGBT, Japan, Human Rights, Legislation, Health, Society

### **Summary**

Assesment through leglative, medical and human rights aspects, of the situation of transgender people in Japan

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## INTRODUCTION

Starting with the Meiji restoration and largely due to the introduction of new “*medical and psychological discourses*” coming from Europe, during the XX century there was a shift in the attitude towards sexual minorities in Japan, an attitude which had previously been more accepting but gradually took onto a more critical, othering perspective based in the conception of “*same-sex desire and cross-gender role presentation (...) as physiological or psychiatric illnesses*” (DiStefano 2008). This resulted in the exclusion of gender variant people from mainstream Japanese society, and their activities, occupations and lives became largely confined to the entertainment world and the sex industry where their “*difference could be capitalized on*” (McLelland 2004). In this context, transgender people and other sexual minorities were mainly seen from a standpoint of “otherness” that focused on “*highlighting their difference from ‘normal’ people*” (McLelland 2004). Therefore, and through this othering of said minorities, in Japan LGBT community members have been typically perceived and represented as abnormal and there has been a failure from both mainstream society and legislation to recognize them at all until relatively recently (DiStefano 2008).

However, even though initially the medical discourse from the early XX century was used to stigmatize LGBT individuals and exclude them from mainstream society, by the end of the 1990s a new medicalized discourse started gaining strength and brought on a new way to “*articulate transgender identity*” (McLelland 2004). This new discourse presented being transgender as a medical condition or disorder which could be medically treated, thus allowing transgender people to leave the margins of society and regain their status as full right citizens after undergoing medical treatment. In that way, the change in the understanding, to some extent, of the meaning of “being transgender” clearly separated the transgender experience confined to the entertainment and sex industries and this “new”, medicalized narrative which presented transgender individuals as “victims” of a psychological disorder which could be treated. This shift in discourse was institutionalized through the passing, in the year 2003, of the “*Act on Special Cases in Handling Gender for People with Gender Identity Disorder*”<sup>1</sup> by the Japanese Diet, which came into effect in the year 2004. While there had already been previous instances where the Japanese legal system had taken a stance on trans-related issues, for example when sex reassignment surgery was resumed on 1998 after its legalization under very strict guidelines for people diagnosed with Gender Identity Disorder (GID) (McLelland 2004) (Oda and Kinoshita 2017), the introduction of the 2003 Act brought, for the first time, the possibility of changing one’s official sex in the *koseki*, thus allowing transgender people to socially and legally transition in all aspects and become part of Japanese society as fully recognized citizens of their desired gender. Moreover, the introduction of this act was supposed to bring on a legal, safe and properly monitored way of accessing the healthcare needed by many transgender people in order to ensure their well being, such as psychotherapy, Hormone Replacement Therapy (HRT) and Sex Reassignment Surgery (SRS).

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<sup>1</sup> “2003 Act” from here on.

While enabling in some aspects and presented as a progressive step towards the acknowledgement of the civil and human rights of sexual minorities in Japan, the introduction of the 2003 Act also brought on a collection of issues with it. Even though the implementation of a law allowing transgender people to legally change their gender in the *koseki* could initially appear as an entirely positive change, the conditions that transgender individuals must comply with in order to be eligible for this gender marker change and the additional conditions that they must meet in order for this change to be granted should also be considered when assessing this new legislation, given that issues such as institutional barriers, gatekeeping or the limitation of transgender people's rights could be implied in the legal pathway established in order to access this newly implemented legal option. Moreover, while it is arguable that on the practical side the medicalization of the transgender condition has positive aspects for the transgender community such as the legalization or recognition of their right to access the healthcare many of them need, it is equally important to consider the detrimental consequences that this categorization can have for both the transgender community at large and the individuals that form it.

Following this line of thought and through the analysis of the legislation and government-issued guidelines concerning transgender people, the goal of this thesis will be to provide a picture of the situation of transgender people in Japan in which both the benefits and the harmful aspects of said legislation and guidelines are analyzed and discussed. The main law that will be analyzed will be the aforementioned "*Act on Special Cases in Handling Gender for People with Gender Identity Disorder*". Its potentially problematic aspects will be highlighted and discussed and, through looking at it from a human rights perspective, an important part of this thesis will also be to establish whether the potential issues arising from said laws and government-issued guidelines concerning transgender individuals translate into any kind of right-violations, abuse or discrimination towards transgender people within Japanese society.

As part of the introduction to this analysis, it should also be noted that many of the issues presented in this thesis are not unique to Japan. While the analysis conducted will focus on Japanese institutions, some of the issues and suggestions for improvement presented throughout this thesis may also relate to legislation, health care and other aspects elsewhere. As such, this analysis shouldn't be taken as a critique of Japanese institutions exclusively, but rather as a focused critical approach on a larger scale, global issue, as institutional discrimination against transgender folk is present in many areas all over the world.

## **THEORETICAL FRAMEWORK**

When looking at previous research conducted on this topic, it is hard to find a comprehensive study that covers all of the aspects targeted by this thesis, as research concerning transgender people in Japan is still limited. However, when talking about a more general picture, one of the main articles

that inspired the approach of this thesis is “*Japan’s 2003 Gender Identity Disorder Act: The Sex Reassignment Surgery, No Marriage, and No Child Requirements as Perpetuations of Gender Norms in Japan*” by Hiroyuki Taniguchi (2013). This article points out many of the main issues that the 2003 Act presents through its limitation and policing of transgender narratives and its ultimately reluctant stance on promoting deeper social change, both when it comes to transgender issues and when it comes to Japanese society at large. Many different issues derived from the 2003 Act are presented in the article, which touches on diverse aspects related to, for example, healthcare, legislation, marriage equality, gender binarism and the limitation of personal freedom among others. By using this article as an initial reference, the reasoning and analysis conducted throughout this thesis will be based on a human rights perspective, being aspects of the 2003 Act and other official guidelines that clash with said rights especially emphasized. Likewise, transgender people’s mental and physical well being will be considered when assessing both the positive and the negative aspects of the 2003 Act.

Moving onto the previously existing studies on the healthcare aspect as relating to transgender individuals, there are some studies available that target transgender people in Japan specifically and which allow us to get an initial idea of the possible barriers and challenges this community faces, as well as providing a more accurate description of the implications of the diagnosis and treatment process that transgender people must undergo in order to change their gender in the *koseki*. Naoya Masumori’s review article on the “*Status of sex reassignment surgery for gender identity disorder in Japan*” (2012) provides a detailed overview of the medical understanding of GID in Japan, its etiology and epidemiology, the diagnostic procedure for the disorder and the available treatment options, including the currently available sex reassignment surgery methods. These specific guidelines for treatment and the type of healthcare mainly available for transgender patients will have effects in their overall health, both physical and mental, and have to be taken into consideration as an essential part of their lives. For example, and in order to provide further contextualization, the guidelines and nomenclature that are still being used in Japan when treating transgender patients belong to an already outdated version of the Diagnostic and Statistical Manual of Mental Disorders<sup>2</sup>. As Roberts and Fantz explain in their article about “*Barriers to quality health care for the transgender population*” (2014) important changes were introduced in the fifth version of the DSM, such as the replacement of the term “Gender Identity Disorder”, which was listed as a condition within the chapter dedicated to sexual dysfunctions, by “Gender dysphoria”, a new category for which a new, separate chapter was also created. This reclassification responded to an effort to reduce stigma and discrimination and improve medical care for transgender patients through changing the notion that they suffer from a disorder (Roberts and Fantz 2014). However, both the healthcare and the legislation in Japan follow the guidelines of the DSM-IV and the “GID” nomenclature still remains. According to the DSM-V,

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<sup>2</sup> “DSM” from here on.

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. (...) Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.

Therefore, even though the inclusion of gender dysphoria in the DSM can be argued as necessary in order for transgender people to receive appropriate medical care, its classification as a “disorder” can be, in the least, questioned, as most of the stigmatization transgender people suffer comes from the perception of their gender expression being seen as “socially deviant behavior”. As mentioned before, the DSM-V partially addresses this issue by introducing the term “gender dysphoria”, which no longer deems transgender people as inherently suffering from a disorder but rather focuses on the treatment of the distress and problems that may arise when gender dysphoria is present in transgender individuals. This change in discourse hasn't yet happened in Japan, at least not on an institutional level, and transgender people are still being deemed as suffering from some sort of disability or disorder.

When profiling the transgender population, works by Okabe et al. (2008) and Terada et al. (2011, 2012a, 2012b) provide us with some statistics on the prevalence of GID in the Japanese population and link it to its relation to other issues such as school refusal, psychiatric co-morbidity and suicidal ideation. According to said studies, transgender people in Japan suffer from higher rates of suicide, self-harm, psychiatric comorbidity, school refusal and unemployment than the general population. Moreover, the FtM-MtF ratio of transgender people in Japan seems to contradict the ratios present in other countries, namely Europe and North-America, being MtF patients less frequent in Japan than elsewhere. However, it should be noted that the accuracy of said studies, specially when it comes to GID's epidemiology, is limited and has important flaws that are expressed by the authors themselves, given that population samples are limited to those coming from patients of GID clinics and the ciphers concerning the general population are just estimates. As Oda and Kinoshita (2017) explain in a more recent study on the efficacy of HRT and psychotherapy in FtM patients,

*researchers who have studied incidence and prevalence have tended to focus on the most easily counted subgroup of gender nonconforming individuals: transsexual individuals who experience gender dysphoria and who present for gender-transition-related care at specialist gender identity clinics.*

While still an unsolvable issue, given that other kinds of formal studies assessing the transgender population have yet to be conducted, this limitation in the assessment of transgender demographics should be taken on account when interpreting and analyzing data. This is also an issue as, when it comes to the transgender community, by looking at native Japanese categories and neologisms used to describe individuals belonging to the LGBT community we can see that the existing language is far from describing only transgender people who adhere to the binary FtM-MtF model that the 2003 Act and healthcare guidelines contemplate. It is important to note that

among the many Japanese categories there are also terms that denote a broader, less binary understanding of gender and sexuality and that speak of the diversity and long history of Japan's transgender community (McLelland 2004). By limiting mainstream studies of the Japanese transgender and gender-variant population to that acknowledged by the existent legislation and individuals presenting to GID clinics, a more diverse and larger community is being erased and underestimated. However unsolvable as of now, this aspect will also be taken on account when conducting the analysis proposed by this thesis.

Another point to take into consideration before moving onto the main analysis is that transgender people not only have to deal with personal feelings of gender dysphoria but also with what it means to be transgender within society, namely with being perceived as "socially deviant". As Anthony S. DiStefano states in his research on "*Suicidality and Self-Harm Among Sexual Minorities in Japan*" (2008), "*to be a sexual minority (in Japan) is to feel incredible stress and pressure*", a pressure which often derives in mental problems and affects personal choices. So, how much of the distress that transgender people experience comes from them suffering from gender dysphoria and how much of it is due to social rejection and other difficulties deriving from it is still unclear. As the WPATH states in their latest version of their "*Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*" (2011),

In addition to prejudice and discrimination in society at large, stigma can contribute to abuse and neglect in one's relationships with peers and family members, which in turn can lead to psychological distress. However, these symptoms are socially induced and are not inherent to being transsexual, transgender, or gender nonconforming.

## **METHODOLOGY**

As can be seen in the introduction, this thesis will take onto three main different perspectives to conduct the proposed analysis: legal, medical and sociological or human rights related. While all three of these perspectives will be integrated throughout the thesis, the legislative state will be the starting point of the analysis. As such, the consequences of laws targetting transgender people both directly and indirectly will be inferred, contrasted and analysed in order to show the legal and social barriers which transgender people face within Japanese society. Moreover, previous analysis of said laws and other supporting documents providing information on their consequences will be used as reference in order to provide a solid background for the reasoning and research that will be conducted throughout this thesis, as seen in the theoretical framework. Official documents and Japanese government sites will also be considered as primary sources from which to obtain information and draw conclusions, be it for or against the existing legislation. When talking about the implications of the said legislation on transgender people's human rights, reports from human rights organizations and NGOs such as Amnesty International will also be used in order to identify any instances of discrimination and abuse that transgender people might be subjected to within



Japanaese society. In this way, news stories and articles may also be used to exemplify such instances if necessary in order to give concrete and recent examples.

### **NOTE ON THE CONCEPTUALIZATION OF SEX, GENDER AND GENDER IDENTITY**

While gender is generally understood as a social construct and a set of cultural and behavioral characteristics associated to a certain gender category -e.g. man or woman-, sex is usually defined as biologically determined by an individual's characteristics as relating to reproductive functions. Additionally, gender identity would refer to gender as is felt by each individual and as a personal experience through which each person identifies -or doesn't- with a certain gender. To summarise, these categories could be explained as sex being biological, gender being social and gender identity being psychological. However, it should be noted that theories conceptualising sex as a social construct are also to be taken into account despite the generalised understanding that sex is intrinsically divided into two separate categories which are naturally determined. In their article "*Sex, Biological Functions and Social Norms: A Simple Constructivist Theory of Sex*" (2016), Åsa Carlson explains the conceptualisation of sex as being based on human values and therefore not explicitly present in nature. As reproduction is considered essential in human societies, sex, a category made according to one's role in reproduction, can be understood as a normative, teleological category given that "*the sex categories depend on norms of reproduction*" (Carlson, 2016). In this way, while many different aspects are taken into account when explaining sex from a biological perspective -chromosomes, hormones, reproductive organs, secondary sexual characteristics- the ultimately defining aspect of the categorisation responds to which function an individual carries out in reproduction. However, just like gender -and sexuality- are not dichotomous categories but rather a spectrum, sex can also be understood as such through both a biological and a sociological point of view. This doesn't mean that, objectively, most humans -not all- possess either one or another set of reproductive organs, i.e. produce either ova or sperm, but a broader understanding of not only gender but also sex can prove essential when discussing non-normative categories concerning sex, gender and sexual orientation given that, as long as said categories are conceptualised as dichotomous normative categories, non-normative identities and experiences which fall outside of said binary, unavoidable categories will inevitably be considered "abnormal" and be understood "as opposed" to normative ones. A good example of this is the use of the word "cisgender", a word that, when generally used, contributes to cisgender people not being seen as the norm. Namely, without a word to describe people whose gender identity aligns with their assigned sex, transgender people are understood as the "other" while cisgender people are understood as simply being "normal"<sup>3</sup>. In this same way, sex and gender being composed of two opposite categories -male/man and female/woman- disregards the existence of a broad spectrum of identities that, as of now, are still understood as non-normative; namely, as existing outside of the norm. On a side note, it should also be noted that conceptualisations of sex and gender as

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<sup>3</sup> While the word "cisgender" is still born from a dichotomous way of conceptualisation where cisgender and transgender are opposite, mutually exclusive categories, it still defies the normativity of "cisgender" being simply understood as "normal".

existing outside of a binary framework are present cross-culturally and have been present historically as well (Richards et al., 2016), thus adding to the argument of said categories as subjective and socially created.

# 1. ANALYSIS OF THE “ACT ON SPECIAL CASES IN HANDLING GENDER FOR PEOPLE WITH GENDER IDENTITY DISORDER”<sup>4</sup>

## 1.1 Issues related to the GID requirement and its institutionalization: Analysis of “Article 2: Definition” and “Article 3(2)”

### ARTICLE 2: DEFINITION

In this Act, “Gender Identity Disorder” means a person, despite his/her biological sex being clear, who continually maintains a psychological identity with an alternative gender (hereinafter, “alternative gender”), who holds the intention to physically and socially conform to an alternative gender, and who has been medically diagnosed in such respects by two or more physicians generally recognized as holding competent knowledge and experience necessary for the task.

### ARTICLE 3: PROCEDURE TO CHANGE THE TREATMENT OF GENDER

2. In making an application as provided for in the previous section, an applicant must submit medical certification indicating the applicant’s status as a person diagnosed with Gender Identity Disorder as provided for in Article 2 above and other matters as may be provided for by Ordinance of the Ministry of Health, Labour, and Welfare, including but not limited to the progress or results of any medical treatments.

As was briefly mentioned in the theoretical framework of this thesis, when looking for positive aspects of the medicalization of the transgender identity its main advantage would be that, theoretically, said medicalization should facilitate trans people’s access to healthcare. Through understanding transgender identity as a medical condition, treatments such as HRT or SRS can be seen as a medical necessity rather than just a personal or arbitrary choice, which can lead to said treatments being more regulated and made readily available for the transgender individuals who need them. Moreover, and as many other medical treatments, the available physical treatments for transgender patients can have negative or undesired side-effects if they are not properly conducted and duly supervised by knowledgeable medical staff. In this way, risks of unregulated access to physical treatment can include, for example, adverse reactions to self-administered cross-sex steroids (HRT) and untreated complications derived from SRS (Masumori 2012) among others. This is why it is important that said procedures are regulated, as through proper regulation and improved accessibility the existing risks can be minimized and healthcare for trans patients vastly improved. However, is the medicalization of the transgender identity necessary in order to regulate and facilitate access to treatment? Also, and focusing on the case of the 2003 Act, does increased regulation and the standardisation of treatment for transgender patients really translate into

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<sup>4</sup> For a reproduction of the 2003 Act see “Annex”

increased accessibility and improved treatment quality?

The instalment of the 2003 Act poses a complex context for transgender individuals, their rights and their access to care. By looking at articles 2 and 3 (2), which state the need for a GID diagnosis and subsequent medical treatment in order to access the *koseki*'s gender marker change process, an initial assessment of the issues related to the pathologization of the transgender category and the need for compulsory medical treatment can be made. While, as argued above, treatment for transgender patients should be regulated and supervised, this is done in a very specific, restrictive way in Japan as can be seen through the 2003 Act itself, which requires transgender individuals follow a concrete and predetermined line of treatment in order to be able to legally transition. Even though medical treatment for transgender patients should have the ultimate goal of alleviating their gender dysphoria and easing their transition into a gender expression they feel comfortable with (The World Professional Association for Transgender Health, 2011), this is disregarded by both the 2003 Act and the treatment guidelines proposed by the Japanese government. In order to better present and discuss this issues, this first section of the analysis (1.1) will deal with issues related to the pathologization of the transgender identity, socio-economic class, the quality of the available treatment, problems with access to treatment (gatekeeping, exclusion), the institutionalisation of a discriminatory cisheteronormative model and the lack of diversity in treatment options.

### **1.1.1 Pathologization**

A pivotal aspect of the 2003 Act lies in the pathologization of the transgender identity, which not only consists of the compulsory need for a GID diagnosis in order to legally and medically transition but is also made explicit through other legislative and medical aspects related to the 2003 Act. For example, when looking at the government issued guidelines for the diagnosis and treatment of GID, it can easily be seen that the approach taken institutionally is that of transgender individuals as suffering from a disorder, since there is a predetermined line of treatment for the “condition” after which patients are not considered to be in need of further physical treatment. As was briefly explained in the theoretical framework of this thesis, in Japan the outdated IV version of the DSM is still being used as the basis for the assessment and treatment of GID. The word for GID in Japanese is 性同一性障害 (seidouitsuseishougai), 性同一性 (seidouitsusei) meaning gender identity and 障害 (shougai) meaning handicap, impairment or disorder. Other words with the same suffix (障害) include, for example, 身体障害 (shintai shougai) meaning “physically disabled person” and 精神障害 (seishin shougai) meaning “mental disorder”. In this same way, GID, is also understood as a disorder or disability for which individuals should be treated, both psychologically and physically. In the official website of the Japanese Ministry of Health, Labour and Welfare (厚生労働省), an informative section dedicated to GID can be found under the category dedicated to

mental illness (こころの病気). Said informative page is divided into 3 main subsections:

- 性同一性障害とは - definition of GID
- 性同一性障害でみられる症状 - symptoms of GID
- 性同一性障害の治療 - medical treatment for GID

In looking at this page, it can be seen how the language used in it is medicalized and refers to physical transition as a treatment for GID itself rather than it being understood from a symptomatic perspective tackling gender dysphoria only. Namely, by inherently associating a set of pathological symptoms which need to be treated to people who do not identify with their assigned gender at birth and wish to legally/medically/socially transition, transgender identities as a whole are being pathologized and understood from a very limited perspective in which only individuals suffering from severe gender dysphoria and who are willing to undergo certain medical procedures are recognized by law as having the right to legally change their gender marker and name and be institutionally acknowledged as full right citizens of their gender. Gender dysphoria is present in transgender individuals in varying degrees of intensity and not all individuals are in need of the kind of treatment that the 2003 Act makes into a requirement in order to be able to modify legal documents. Moreover, and as was briefly explained in the theoretical framework of this thesis, pathologization of transgender identities as a whole has negative consequences for the transgender community at large, as it leads to stigmatization rather than understanding and acceptance. Stigma associated to a particular group brings on prejudice and discrimination towards said group within society, and through that stigma, prejudice and discrimination, transgender and gender non-conforming people are subjected to minority stress, a unique type of stress “*added to general stressors experienced by all people*” which makes minority groups “*more vulnerable to developing mental health concerns such as anxiety and depression*” (The World Professional Association for Transgender Health, 2011). As Anthony S. DiStefano expresses through a testimony in his research on “*Suicidality and Self-Harm Among Sexual Minorities in Japan*” (2008), “*to be a sexual minority (in Japan) is to feel incredible stress and pressure*”, a clear example of the aforementioned minority stress. Moreover, the stigma derived from identities under the trans umbrella being understood as an illness and something inherently pathological “*can contribute to abuse and neglect in one’s relationships with peers and family members, which can lead to psychological distress*” as well (The World Professional Association for Transgender Health, 2011).

Fighting stigma and taking steps towards inclusion, as was done in the DSM-V by removing the medical term “GID” and institutionalising the use of “Gender Dysphoria” instead, is crucial when it comes to the transgender population specifically, as studies have corroborated that transgender people in Japan are at a higher risk of suicide, self-harm, psychiatric comorbidity, school refusal and unemployment than the general population (Okabe et al., 2008; Terada et al., 2011, 2012a, 2012b). Identifying and working towards solving the issues transgender people as a population are

affected by and that are causing these differences between them and the general population is essential in order to ensure their safety and facilitate their integration in society as well as in order to move towards generalised acceptance and understanding from Japanese society at large.

Lastly, the view of gender variance being understood as a “disorder” with a predetermined line of treatment after which patients are considered to be in no need of further physical treatment can also have a harmful effect in how transgender individuals understand themselves and relate to their own identity. Since treatment is not focused on alleviating each individual’s gender dysphoria through targeting the aspects which are important to them personally but rather is made following a specific model equal for all patients, transgender individuals can still be dissatisfied after undergoing treatment and feel uncomfortable with their gender presentation and their bodies due to misinformation. There should be room for self-exploration within gender transition given that gender dysphoria can be present in different ways and intensities and treatment which may be ideal for one patient can be undesirable for another. If transgender people are led to believe that after following the transition process outlined by the 2003 Act and government-issued guidelines they will be “cured” of their dysphoria and that SRS should be the ultimate goal of their transition, self-exploration and assessment of proper treatment options can be neglected leading to an unsatisfactory transition process and a misunderstanding of the goals of physical transition which is alleviating each individual’s gender dysphoria rather than conforming transgender bodies to cisnormative beauty standards.

### **1.1.2 Quality of treatment and availability**

Besides pathologization and its negative consequences, the need for a GID diagnosis and subsequent compulsory medical treatment faces transgender individuals with other added difficulties. In the introduction to this section the need for treatment regulation and supervision was argued as necessary; however, the effectivity of the 2003 Act in ensuring equal access to healthcare was put into question. In this case, it can be argued that increased regulation doesn’t inherently translate into increased accessibility and an overall safer path to physical transition for transgender people as, despite HRT and SRS being made compulsory treatments in order to legally transition, “*the number of medical clinics/hospitals that are involved in physical treatment for the condition is still insufficient*” as “*there are very few institutions that routinely carry out SRS (in Japan)*” (Masumori 2012). In this way, despite the growing number of people seeking treatment and identifying as transgender, the number of GID clinics is still limited, a factor which contributes to the unauthorized administration of cross-sex hormones (Oda and Kinoshita 2017) and leads people to look for treatment options outside of Japan. The limited number of GID clinics together with the long time needed for transgender patients to get approved for physical treatment poses an issue for transgender people urgently seeking official medical treatment in Japan (Masumori 2012), and this situation is especially hard for trans-masculine patients, as even though vaginoplasty is more widely performed due to its lesser difficulty, “*penis construction is*

performed at only a few hospitals” as it “requires a high level of technical skill” (Okabe et al., 2008). Phalloplasty, one of the techniques used in SRS for transgender men “is the most expensive and hardest to obtain”, as few hospitals perform it and it costs around 2 million yen (Stonewall Japan 2016). Furthermore, “(i)t is likely that some patients have excessive expectations of SRS and do not always understand the risks of invasive surgery” (Masumori 2012), which means not all patients are properly informed of the risks, implications and real results of SRS and in some cases regret undergoing said surgeries.

One last point to consider is that although sexual organs can be constructed through surgery, they cannot yet be made into fully functional organs. For example, in the case of penis construction - phalloplasty-, despite external genitalia resembling that of a cisgender male an erection cannot occur naturally. Again, this makes SRS not critical or even desirable for many transgender individuals who do not suffer from severe gender dysphoria. However, despite its limitations - specially for trans men-, monetary cost, difficult recovery and other issues SRS is still mandatory in order to access the 2003 Act.

### 1.1.3 Class

Another issue stemming from HRT and SRS being compulsory in order to change one’s sex in the *koseki* is that despite it being the institutionally established line of treatment, said medical procedures are, to this date, not covered by national insurance. The only treatment for transgender individuals covered by national insurance is psychotherapy (Masumori 2012)(Okabe et al., 2008) (Stonewall Japan, 2016)(“Proposed rule change on coverage of sex reassignment surgery boon to GID sufferers in Japan, but concerns linger,” 2017). When looking at transgender people’s reality, because of the lack of coverage and despite treatment regulation within Japan many patients still choose to have surgery performed outside of the country as it is cheaper and easier to access, and in some cases also opt for the use unauthorized cross-sex steroids<sup>5</sup> (Masumori 2012) (Oda and Kinoshita 2017) (Okabe et al., 2008). For example, in a study conducted in the GID Clinic of Okayama University Hospital between April 1, 1997 and October 31, 2005 it was found that

At first examination, 212/349 (60.7%) of the FTM-type GID patients and 108/230 (47.0%) of the MTF-type GID patients had not undertaken hormonal or surgical therapy (...). Within the two groups, 36 of 349 (10.3%) FTM GID patients and 33 of 230 (14.3%) MTF GID patients had already undergone total or partial sex reassignment surgery (...). (Okabe et al., 2008)

Besides, in the same study it was found that many patients who had already undergone total SRS would go to the Okayama University Hospital just “to get a medical certificate to legally register the change” (Okabe et al., 2008). As was previously mentioned, many transgender patients choose

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<sup>5</sup> In some cases patients undertake HRT through a regular endocrinologist/urologist’s prescription without previously undergoing psychological assessment/counseling in order to avoid the added waiting time the pre-HRT treatment entails (Oda and Kinoshita 2017).

to have SRS performed abroad given the limited surgery options and the few available clinics and hospitals conducting SRS in Japan. When adding those issues to the elevated cost of SRS, which is considerably more expensive in Japan than in, for example, Thailand, the preferred destination for transgender patients seeking SRS and other surgical gender reaffirmation procedures<sup>6</sup> (Stonewall Japan, 2016), the SRS requirement of the 2003 Act poses a clear class issue for transgender individuals who are unable to afford the indispensable medical care. Just to provide some concrete examples of the cost of gender reaffirmation surgeries in Japan, in the case of transgender men mastectomy “*ranges from 400,000 yen to 1.3 million yen, with the average cost (being) around 80,000 yen*” and as previously mentioned phalloplasty “*is the most expensive and hardest to obtain at around 2 million yen*” (Stonewall Japan, 2016). When focusing on trans women, breast augmentation ranges from 300.000 to 900.000 yen and vaginoplasty “*costs an average of 1.9 million yen*” (Stonewall Japan, 2016)

As can be seen, surgery and HRT being compulsory but not financially covered introduces a class variable into both the legal and the medical processes, and in some cases this can lead to unpaid fees interfering with operation of GID clinics (Masumori 2012). Through making a costly procedure such as SRS compulsory, people who cannot afford to undergo said surgery are immediately excluded from access to the 2003 Act, which means they are denied the possibility of full legal and social transition as well, and while there has recently been a proposal by the Japanese Health Ministry to include SRS in the national health insurance, said proposal has yet to come into effect and is still being discussed (“Proposed rule change on coverage of sex reassignment surgery boon to GID sufferers in Japan, but concerns linger,” 2017). It should also be noted that as “*(g)overnment services (...) operate from an LGBT-exclusionary framework*” there are incongruences when it comes to health coverage such as, for example, cisgender men and women undergoing hormonal treatments being able to have hormone therapy covered under Japanese National Health Insurance while transgender men and women have to pay for HRT themselves (Stonewall Japan, 2006). In the case of HRT, its cost ranges from 3500 yen per month for oral medication -commonly used by trans women- to 9000 yen per month for injections -commonly used by trans men (Stonewall Japan, 2016). Also related to the issues caused by the cisnormative framework the healthcare system operates by is the access to medical care post-SRS. For example, “*if a trans man needs some kind of gynecological treatment after getting a legal sex change, there's no way to get it covered with a health insurance card listing a male gender*” (Stonewall 2016) which can also pose a problem for some patients when seeking medical care after having changed their gender marker and name in the *koseki*.

#### **1.1.4 Barriers in access to treatment and limitations**

Another issue stemming from compulsory GID diagnosis which makes regulation not inherently translatable into improved access to treatment is gatekeeping. Transgender individuals who don't

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<sup>6</sup> For a more detailed price comparison see “Stonewall Japan's Trans\* Guide to Japan 2016” (Stonewall 2016)



adhere to the institutionalized definition of GID and who don't comply with the criteria for GID diagnosis are not only kept from legally transitioning but are also deprived from accessing physical treatment in an authorized way. The process for GID diagnosis and the obligatory psychotherapy preceding medical treatment are long and complex, as they include thorough mental examinations and interviews, physical exams of sexual organs -both external and internal-, checking of chromosome and hormone levels, and a supervised social adaptation period to one's gender called "real-life experience", a mandatory "trial" period in which individuals are required to "live as their desired sex in everyday activity to assess whether" they can deal with the situations and problems that arise "in daily life as the opposite sex", a process which usually takes more than 12 months (Masumori 2012)(Stonewall Japan, 2016). In this way, transgender patients are not only required to prove themselves as being able to live as their gender in daily social settings pre-transition but are also forced to come out in terms which may compromise their safety and mental well being. Moreover, in cases in which patients may be in urgent need of medical transition, said transition is delayed through this process -usually at least for a year- as patients have to be diagnosed with GID and prove their transgender identity in very specific terms before being given access to physical therapy. While it is essential to properly inform patients of the effects, physical risks, social consequences and other important aspects of, for example, HRT, as well as to assist them into making "fully informed decisions", all decisions regarding healthcare should always be "first and foremost" the patient's own decisions, not an imposition, as the ultimate goal of physical treatment for transgender patients is that of alleviating their gender dysphoria (The World Professional Association for Transgender Health, 2011). Forcing patients to undergo SRS goes against the medical guidelines of the Japanese Society of Psychiatry and Neurology as well, as they "require that medical professionals must be well aware of and have respect for the self-determination of individuals with GID when discussing possible approaches to treatment" (Taniguchi 2013).

As per the interviews conducted during the assessment of the presence of GID, physicians look for signs of GID by asking about "histories of nurture, lifestyle and sexual behavior, the actual status of gender dysphoria, such as a discomfort and **disgust with one's sex**, a strong and persistent **cross-sex identification** and requirement for a **cross-gender role** (emphasis added)" (Masumori 2012). Similar criteria can be found when looking at the GID definition provided by the 2003 Act:

In this Act, "Gender Identity Disorder" means a person, **despite his/her biological sex being clear**, who continually **maintains a psychological identity with an alternative gender** (hereinafter, "alternative gender"), who **holds the intention to physically and socially conform to an alternative gender**, and who has been medically diagnosed in such respects by two or more physicians generally recognized as holding competent knowledge and experience necessary for the task. (emphasis added)

Both of this fragments present a very concrete and defined picture of the transgender experience accepted as valid in order to legally transition and be deemed as disordered rather than just socially deviant. In the definition provided by the 2003 Act modelled after the outdated DSM-IV, there is a

clear divide between one's sex/body and one's psychological identity. These two entities are seen as separate and mutually exclusive, and acceptance of one (psychological) must imply hatred and/or rejection of the other (physical). Moreover, each of the categories are seen as inherently binary, with a divide between male and female in the physical sense and man and woman in the psychological one. Again, in this context both male/female and man/woman are understood as dichotomous, mutually exclusive categories which cannot coexist and which must match up in an individual (male = manhood = man/female = womanhood = woman). As can also be seen through both definitions, the aforementioned categories are understood as having a set of predetermined roles and social functions attached which must also be present in the individual according to their psychological identity. Without an intention of "*physically and socially conform(ing) to an alternative gender*" or the presence of a "*cross-gender role*", sole identification with a gender different from that assigned at birth is insufficient. In this way, any transgender person who doesn't adhere to this defined, binary narrative is left outside of the institutional discourse concerning transgender individuals and, as already mentioned in the theoretical framework, most of the patients presenting to GID clinics in Japan fit the institutionalized profile of severe gender dysphoria (Oda and Kinoshita 2017), a profile which makes up only part of the transgender experience. In short, equating GID to transgender identity can easily translate into the gatekeeping of individuals who do not fit the institutional model and thus lead to unregulated access to surgery and hormonal treatments as well as societal exclusion given the inability of those people to access legal and medical transition mechanisms. Restricted access to medical transition can also mean being more easily subjected to abuse, harassment and discrimination for some transgender individuals who would want to medically transition but are unable to, as it makes it harder for them to "pass" as cisgender and it forces them to disclose their transgender identity if they wish to socially transition. This is also a direct consequence of the pathologization of the transgender identity, as anyone who is left outside of the set of symptoms and line of treatment established as "official" or medically acceptable is also left outside of the current system and cannot access full legal transition. This is not to say that a set of guidelines in order for technicians to recognize symptoms of gender dysphoria and be able to assist patients to medically transition is unnecessary, quite the contrary, but when said guidelines come from understanding transgender identity as a mental disorder and provide a narrow, predetermined path of treatment which only recognizes one type or severity degree of gender dysphoria and does not take into account the patients' personal preferences many issues arise.

The pathologization of the transgender experience and the requirement for a predetermined treatment path in order to access legal transition also translates in a lack of diversity in treatment options for transgender patients. Even though medical treatment for transgender individuals should have the ultimate goal of alleviating each individual's gender dysphoria (Masumori 2012) (The World Professional Association for Transgender Health, 2011) the 2003 Act fails to contemplate this. As will be argued in the next section of this thesis, the 2003 Act ultimately upholds a cisheteronormative social model which is not inclusive of transgender experiences at

large; it is made in order to adapt transgender people to the already existing system rather than made to adapt the already existing system to transgender people's reality. In this way, it marks a very specific treatment path for all transgender individuals and fails to recognize other treatment options which may be in fact available and more effective for some individuals but are not mentioned in the 2003 Act nor in the informative page dedicated to GID on the Japanese Ministry of Health, Labour and Welfare's website, thus failing to acknowledge the existing diversity within the transgender community and each individual's freedom of choice and agency over their bodies. For some transgender individuals, surgeries other than SRS such as mastectomy for trans-masculine individuals and facial feminization surgery for trans-feminine ones can be more effective and urgent/critical in alleviating their gender dysphoria, as some transgender people do not even suffer from bottom dysphoria or simply do not want to undergo genital reconstruction. As Roberts and Fantz (2014) state in their article about "*Barriers to quality healthcare for the transgender population*", "(t)reatment for gender dysphoria has become more individualized and **may or may not involve** a change in gender expression or body modifications" (emphasis added). Moreover, the SRS requirement erases all other transgender narratives and leads to other different forms of gender dysphoria to be disregarded and ultimately not respected (Stonewall Japan, 2006).

Lastly, one more possible issue facing transgender individuals who seek medical treatment and that is also related to the pathologization of the transgender identity has to do with the diagnosis of GID itself. Through gender dysphoria being understood as a symptom of mental illness and as was previously mentioned, a diagnosis of said illness (GID) is necessary in order to access treatment and be considered transgender. Issues can arise when comorbidity is present in transgender patients, as patients suffering from some illnesses such as schizophrenia and/or personality disorders are more likely to be turned down when trying to access GID clinics. For example, in the study by Okabe et al. (2008) about the "(c)linical characteristics of patients with (GID) at a Japanese (GID) clinic", 4% of patients presenting to the clinic were denied treatment as follows: "*Four patients were excluded for transvestic fetishism, eight for homosexuality, five for schizophrenia, three for personality disorders, and four for other psychiatric disorders*". In this way, while it is important to assess comorbidity and treat co-existing conditions, the presence of certain psychological or psychiatric disorders should not inherently be a reason to dismiss the presence of gender dysphoria or understand transgender identity as a "symptom" of another mental disorder. According to the WPATH, some of the health concerns that can be present in transgender patients include "*anxiety, depression, self-harm, a history of abuse and neglect, compulsivity, substance abuse, sexual concerns, personality disorders, eating disorders, psychotic disorders, and autistic spectrum disorders*" (The World Professional Association for Transgender Health, 2011). As such, while the presence of other health concerns should not immediately signify the dismissal of treatment for gender dysphoria,

Mental health professionals should screen for these and other mental health concerns and incorporate the identified concerns into the overall treatment plan. These concerns can be significant sources of distress and, if left untreated, can complicate the process of gender identity exploration and resolution of gender

dysphoria. (...) **The presence of co-existing mental health concerns does not necessarily preclude possible changes in gender role or access to feminizing/masculinizing hormones or surgery;** rather, these concerns need to be optimally managed prior to or concurrent with treatment of gender dysphoria. In addition, clients should be assessed for their ability to provide educated and informed consent for medical treatments (emphasis added) (The World Professional Association for Transgender Health, 2011).

## 1.2 Issues related to the upholding of a cisheteronormative system: Article 3

Section 1.2 of this analysis will focus on the 2003 Act's sections which have mainly sociological implications affecting the freedom of choice and personal life of transgender individuals. While section 1.1 mainly worked from a medical framework that, while also having sociological implications only analysed the issues related to the pathologization of the transgender identity and the standardization of medical treatment for all transgender patients in order to access the 2003 Act, this second part of the analysis will look at the articles that aim for the upholding of a cisheteronormative gender system specifically. As such, this section will be divided into 3 main sub-sections classified by topic which will address sections IV-V, II-III and I of article 3 of the 2003 Act respectively and will deal with issues such as the psychological costs of SRS and sterilization, the forced exclusion of transgender people from the family system, the policing of trans people's sexuality and private life and age-sensitive questions among others.

### **1.2.1. Sections IV-V: The loss of reproductive capacity and cisnormativity**

IV. The person does not have gonads or permanently lacks functioning gonads; and

V. The person's physical form is endowed with genitalia that closely resemble the physical form of an alternative gender.

Sections IV and V deal with aspects concerning the state of both the external and internal reproductive organs of transgender individuals at the time of their legal transition. Some of the negative aspects of SRS being compulsory such as economic costs, lack of consideration for personalised treatment options and treatment quality and accessibility were discussed in the previous section of this analysis (1.1). Therefore, this section will mainly focus on the consequences that a loss of reproductive capacity entails, an aspect that wasn't examined in depth in 1.1.

Firstly it should be noted that making sterilization compulsory as part of the treatment for gender dysphoria is not justifiable from a health care perspective, as being transgender doesn't inherently mean rejecting one's reproductive organs or reproductive ability. In fact, many transgender people want to reproduce and look forward to forming their own families (Rainbow Health Ontario, 2014)<sup>7</sup> (Stotzer, Herman, & Hasenbush, 2014). Nevertheless, there seems to be the misconception that transgender individuals either do not want to make use of their reproductive capacity or

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<sup>7</sup> "Research conducted with trans men in Belgium found that 54% wished to have children, and 37.5% would have considered freezing their eggs (...). Similar research with Western European trans women found that 40% wanted to have children, with 56% of lesbian and bisexual trans women expressing interest in using their own sperm, compared with 13% of straight trans women. Many regretted losing the opportunity to parent genetically related children, and 77% felt the option to preserve sperm should be routinely offered to all trans women." (Rainbow Health Ontario, 2014)

simply become unable to do so after physically transitioning, which is not entirely true. For example, and as explained in the previous section, given that physical transition doesn't imply the same medical treatment for all transgender patients, whether they can/want to reproduce will largely depend on factors such as at what point of their transition they are on and what medical procedures, if any, they wish to undergo in the future. Secondly, gonadectomy is the only surgical procedure that deems transgender patients definitely infertile, whereas other common treatments such as HRT do not necessarily entail a loss of reproductive capacity. In the case of transgender people with ovaries and uterus, pregnancy may occur even while undergoing HRT as even though *"testosterone therapy usually leads to anovulatory state and amenorrhea"* (Amato, 2018) it does not act as a contraceptive and pregnancy may occur especially at the start of HRT (Rainbow Health Ontario, 2014). Moreover, if HRT is stopped, transgender individuals with uterus and ovaries can regain fertility, and 80% of them will resume menses *"within 6 months of stopping testosterone"* (Amato 2018). In the case of transgender people with testes, individuals' *"testicular volume is greatly reduced by long-term estrogen use, impacting the maturation and motility of sperm"* and as such it is advisable for them to bank sperm before starting HRT if they want to ensure the possibility of reproduction in the future (Rainbow Health Ontario, 2014). However, for transgender people with testes who are already undergoing HRT, hormone therapy can be stopped for a few months in order for sperm quality to improve before banking. It should also be noted that it is possible for transgender women to breastfeed if their breast tissue develops sufficiently through HRT and that milk production can be stimulated through medical treatment (Rainbow Health Ontario 2014), a practise that has been ongoing for years unofficially but was first academically documented and reported in January of 2018 (Reisman & Goldstein, 2018). As explained and given that reproduction is possible for fertile transgender individuals they should always be informed of reproductive options before starting medical transition so they can make an informed decision about their reproductive health and their transition process. Fertility preservation can also be an option if transgender patients wish to go through with physical transition or undergo a gonadectomy such as through sperm banking or egg freezing (Rainbow Health Ontario, 2014). However, the cost of said fertility preservation and other posterior fertility treatments can be a problem for some individuals who may have difficulty to afford them. For example, in the case of transgender individuals who can ovulate, *"it costs about ¥700,000 to preserve 10 frozen eggs for one year, including the cost of collecting the eggs for cryopreservation (...). An additional fee of around ¥10,000 per egg is required to extend cryopreservation by one year"* (Ogawa, 2014). Moreover, and leaving treatment costs aside, the compulsory removal of transgender individuals' gonads in order to legally transition goes against said individuals' right to form a family and takes away agency over their own bodies and their medical choices. In fact, a transgender man, Takakito Usui, pleaded to the Hiroshima High Court to be allowed to change his sex in the *koseki* without undergoing SRS and later appealed the court's ruling denying his petition arguing that *"the law requiring sterilization is "unconstitutional" as it violates the Constitution's guarantee of people's right to be respected as individuals"* and *"Article 13 of the Constitution because it requires (invasive) surgery that does tremendous damage to a person's body"*, while

also criticising “*the law for being “out of touch with reality”*” (Ogawa & Nikaido, 2017). Takakito wants to marry his partner -a woman- as a man, but is as of now unable to do so because of his refusal of being sterilized. In some other cases, transgender individuals may feel that “*they have no choice but to go in for surgery (in order) to marry or for their work*” (Ogawa & Nikaido, 2017).

As has been emphasized thus far, not all trans people wish to undergo SRS and gonadectomy, as their gender dysphoria may be focused in other aspects of their appearance/body or medical transition may mean a different path for them. Even for some transgender patients who wish to undergo SRS it can be difficult to come to terms with fertility loss. In this way, making certain procedures/treatments compulsory goes against the purpose of physical transition, as previously explained, and plays into the narrative of transgender people as suffering from a mental disorder for which a standardized line of treatment is needed. Moreover, it also keeps people unwilling to adhere to the 2003 Act’s conditions from legally transitioning. One more aspect to take into consideration when talking about reproductive health as relating to transgender people is that, given that health systems operate from a cisnormative framework, it can be difficult for transgender patients to get adequate care when it comes to their reproductive health as medical professionals may not be familiar with their needs. Trans people may thus also suffer from discrimination or discriminatory medical practices, such as issues regarding the coverage of hormones or restricted access to gynecological care for transgender men, as was previously explained (see 1.1.3).

Lastly, and focusing on section V of the 2003 Act, it can be seen that this legislation sees transgender people as having the ultimate goal of meeting cisnormative beauty standards or rather pushes for medical transition to bring transgender individuals closer to the standard of a typical cisgender body as can be seen through section V which requires that “*the person’s physical form (be) endowed with **genitalia that closely resemble the physical form of an alternative gender***”. In this way, not only do trans people need to undergo SRS but the goal of said surgery should be to construct genitalia as similar as possible to that of a cisgender individual, thus reinforcing a binary, cisnormative gender system which disregards gender variance and gender non-conformity. This legislation is also a way of “avoiding trouble” in regards of having to work towards inclusion of gender-variant people with non cisnormative bodies into society and the Japanese health system. This can be seen, for example, in the arguments that were given by both the court and the Japanese Justice Ministry when justifying the aforementioned denial of a transgender man’s appeal to change his sex in the *koseki* without undergoing surgery, with statements such as “*It is interpreted that the operation requirement was based on the understanding that keeping the reproductive ability of the sex an individual was born as is not appropriate*” and that “*the surgery requirement was put in place to avoid “various confusion and problems that would arise when a child was born because of the reproductive ability retained from the former sex”*” (Ogawa & Nikaido, 2017).

### 1.2.2. Sections II-III: A cisheteronormative family model

II. The person is not presently married.

III. The person doesn't have a minor child.

Sections II and III deal with aspects directly related to family relations as they state that at the time of legal transition, transgender individuals cannot be married nor have minor children. The no-marriage requirement stems from same-sex marriage being unlawful in Japan, namely not being recognized by the law on a country-wide basis. Therefore, there is no provision for what would happen if someone married into a heterosexual marriage were to legally change their gender, as it would make the couple now homosexual in the eyes of the law. To avoid this legal issue, the 2003 Act includes a no-marriage requirement which takes said legal vacuum out of the equation rather than addressing the lack of legislation allowing non-heterosexual couples to register their relationships and gain marital benefits. As such, this is not only an issue which affects transgender people but rather the LGBT community at large, as any families outside of a heteronormative framework are currently excluded from the legal family system. In this way, and as was seen in the previous section as well, Japanese law is not equipped for dealing with any instances of non-cisheteronormative families, exemplified in ways such as the lack of provisions for the logistics concerning legal documents if a transgender man were to become pregnant and deliver a child. Nonetheless, in the context of Japanese society, marriage and family relations are socially significant, since given the *koseki* registration system that is still in place, the basic social unit is the family rather than the individual. Moreover, the continuation of the family lineage has been traditionally seen as an important duty of family members, and in this way, “*the idea of continuing one’s family lineage through marriage is still commonly shared in Japanese society. Therefore, in Japan, marriage is never merely a private matter but also requires a deep consideration regarding family*” (Arai, 2014). As can be seen through that affirmation, both the previously discussed loss of reproductive capacity and the no-marriage requirement directly clash with aspects and duties that are considered significant within Japanese society. By being denied both marriage and reproductive rights, transgender individuals are being deprived, by law, of potentially important aspects of their lives if they wish to legally transition.

Another issue coming from section II is that transgender people that are married at their time of transition are forced to either divorce their partners -without the possibility of remarrying them- or give up their legal transition in favour of preserving their family ties. This can place a psychological strain on transgender individuals as well as their partners and families as it forces them to choose between completing their legal gender transition, thus being forced to divorce with all of the social, emotional and financial implications this entails, or having their legal documents not reflect their real sex, something that can often come in conflict with their outer appearance or gender presentation and interfere with their social transition and daily life. Just like the section requiring sterilization, section IV goes against transgender individuals’ personal freedom and is in conflict with their human and constitutional rights.



Section III of the 2003 Act is a requirement unique to Japan (Taniguchi, 2013) and forbids transgender people of having underage children at the time of transition. This is based on many harmful misconceptions such as that transgender people are mentally ill and therefore unable to take proper care of their children; that having a transgender parent can be harmful for a child; that living through a parent's transition can be a traumatic experience for a child; and the implied notion that growing up inside of a non-cisheteronormative family can be detrimental for a child. As the notion of transgender people as mentally ill and how said misconception can be damaging for transgender folk was already discussed, issues regarding having a transgender parent being understood as harmful or traumatic for a child will now be addressed. First of all, it should be noted that, according to different studies, there is no evidence supporting the fact that having a transgender parent can have adverse effects on a child's development nor influence the development of their gender identity or sexual orientation (Stotzer, Herman, & Hasenbush, 2014). In fact, most transgender parents report having a good relationship with their children, and for most transitioning parents, there were either positive or no changes in the relationship with their children during and post-transition (Stotzer, Herman, & Hasenbush, 2014). Moreover, it should be noted that *“main stressors for children during their transgender parent's “coming out” process were **due to tension between the parents and processes of divorce/relationship dissolution that may ensue, rather than stress about the gender transition itself**”* (emphasis added) (Stotzer, Herman, & Hasenbush, 2014). In this way and contrarily to the reasoning followed in making the 2003 Act, studies suggest that losing contact with a transitioning parent through circumstances such as the parent's divorce can have adverse effects for the child while having a transgender parent can actually *“increase some positive outcomes, such as by (the transgender parent) teaching their children about accepting individual differences and diversity and by being open-minded”* (Stotzer, Herman, & Hasenbush, 2014)<sup>8</sup>, an aspect that can be important in the child's life as family acceptance of LGBT adolescents is *“associated with young adult positive health outcomes (self-esteem, social support, and general health) and is protective for negative health outcomes (depression, substance abuse, and suicidal ideation and attempts)”* (Ryan, T. Russell, Huebner, Diaz, & Sanchez, n.d.). Another point conflicting with the reasoning followed by the 2003 Act in including the no-child requirement is brought up by Taniguchi (2014) in his article analysing the legislation, where he points out that, in the case of a transgender individual having a minor child but wishing to transition, the impossibility of doing so can put a strain in the parent-child relationship, be it by the parent resenting their child or by the child feeling guilty for “being in the way” of their parent's gender transition, which is not good for the child's welfare either.

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<sup>8</sup> For a review of existing research on transgender parenting, see “Transgender Parenting: A Review of Existing Research” by Stotzer, Herman, and Hasenbush (2014).

### 1.2.3. Section I: Transition as an adult decision

#### I. The person is 20 years or older

While the guidelines for the diagnosis and treatment of GID by the Japanese Society of Psychiatry and Neurology include a section on treatment options for prepubescent children and adolescents (日本精神神経学会・性同一性障害に関する委員会, 2012) Japanese legislation is not inclusive of transgender individuals under the age of 20. In this way, gender transition is portrayed as an adult decision which cannot be made until a person becomes of age despite gender dysphoria and a wish for social and/or physical transition being present in younger people as well.

Part of the reason why social and medical transition is seen as an adult decision rather than an evolving process is that, in countries with a legislation such as Japan where gender dysphoria is highly pathologized and medicalised, both medical and social transition are seen as very radical, permanent changes which entail major modifications in the body. Namely, in this conception of transgender narratives, identifying as transgender is linked to non-reversible treatments such as SRS, mastectomy, breast augmentation and HRT and to a very strong, unbearable self-hatred towards one's body and sexual characteristics. Through this conceptualization, a binary and dichotomous view of gender is created where even developing children must adhere to one of the two existing categories -man or woman- and its assigned roles and presentation without the existence of an outside or in-between space allowing them freedom to experiment and make a healthy transition into adolescence and adulthood, as transgender identity and gender non-conformity are associated to negative feelings of suffering and self-rejection and thus considered undesirable. However, and even more so in the case of children, gender dysphoria or gender non-conforming attitudes can rather be taken as a cue to self-exploration: an exploration of one's gender presentation, gender roles and the feelings related to such aspects, as for most children that present signs of gender dysphoria, these do not last into adulthood (The World Professional Association for Transgender Health, 2011). However, and as the child's best interests should always be prioritised and their identity respected (Amnesty International, 2016), a child's natural wish for self-exploration of gender should also always be allowed. Moreover, should signs of gender dysphoria persist into late childhood and adolescence, steps can be taken to ensure a safe and monitored medical and/or social transition "*as soon as pubertal changes have begun*" as "*the persistence of gender dysphoria into adulthood appears to be much higher for adolescents*" (The World Professional Association for Transgender Health, 2011). In this way, legal transition mechanisms which can in turn help ease social transition should be available for underage individuals to ensure that transgender people who become aware of their trans identity before becoming of age can lead a healthy transition into adulthood and have adequate agency over their bodies and medical choices.

## 2. ANALYSIS OF THE STATUS OF THE HUMAN RIGHTS OF TRANSGENDER PEOPLE IN JAPAN

While legislation and the availability of public support and health services is important to transgender people's wellbeing, social acceptance and day-to-day relations are also essential as *"health is dependent upon not only good clinical care but also social and political climates that provide and ensure social tolerance, equality, and the full rights of citizenship"* (The World Professional Association for Transgender Health, 2011). In Japan, it is not rare for sexual minorities to hide their gender identity and sexual orientation as they *"still fear the consequences of disclosing their sexuality such as rejection by family and friends, losing a job or housing, and exclusion and isolation from community"* (Yamashita, Gomez, & Dombroski, 2017). In fact, *"online research targeting gay and bisexual men revealed that 80% of the respondents were not out to their parents about their sexual orientation and that 60% of them had not come out to anyone"*, while another similar study showed that *"only 22.5% of people of sexual minorities have experiences of coming out to someone"*, data that signals towards LGBT identities as still suffering from generalised invisibility, stigmatization and discrimination in the country (Yamashita, Gomez, & Dombroski, 2017). As such, this section will aim to provide concrete examples and instances where transgender individuals are routinely discriminated against as well as to point out areas where the lack of legislation directed towards eradicating said discriminatory practices contributes to the perpetuation and institutionalisation of inequities. In the previous sections, some of the instances where the 2003 Act clashes with trans people's human rights were presented. This section will briefly review those aspects and introduce other discrimination issues through information obtained from NGO reports, journal articles and news pieces.

### 2.1. Family and marriage

Some instances of discrimination against trans people were mentioned in relation to the 2003 Act, such as forceful sterilization and other restrictions for transgender and non-cisheteronormative individuals wishing to form their own families (see sections 1.2.1 and 1.2.2). However,

the right to marry and to found a family is protected under international and regional human rights laws including in the Article 23 of the ICCPR recognizing right to marry and to found a family, and the Article 17 of the same Covenant which protects the right to respect for private and family life. (Amnesty International, 2016)

Nonetheless, transgender people may have to divorce their partners in order to obtain a gender marker change, or alternatively may be unable to marry their partner if they are in a homosexual relationship. Apart from the emotionally and socially damaging aspects this might entail, practical consequences of not being able to marry one's partner are not insignificant, as they translate into, for example, couples not being able to access each other's health insurance or *"request family care leave when taking care of a partner"* (Amnesty International, 2016). Other instances of inequality

in rights as opposed to married heterosexual couples include not being able to visit their partners during hospitalization, give consent to medical treatment or be informed of their partner's medical condition (Amnesty International)(Yamashita, Gomez, & Dombroski, 2017). Couples are also unable “*to claim tax exemption for spouses and to have joint custody of an adopted child*” (Amnesty International), while “*right to inheritance and spousal pension benefit*” is also unlawful (Gay Japan News, 2013). Moreover, adoption itself can be extremely difficult for homosexual couples as they are not considered as a family unit and cannot marry. In addition, when it comes to emergency situations such as natural disasters,

In heterosexual marriages or de facto marriages, people are informed whenever their spouses are killed by disasters, but this is not required to happen for same-sex partners, who are not likely to be informed of their partners' death unless their family, friends, colleagues or neighbours knew of the same-sex relationship and would kindly inform them. (Yamashita, Gomez, & Dombroski, 2017)

Homosexual couples may also find themselves unable to access joint temporary housing after a natural disaster as they are not considered a family unit nor married (Yamashita, Gomez, & Dombroski, 2017).

Lastly, and as was briefly mentioned in section 1.2.2, transgender individuals who have children may have trouble being recognised as the child's parent -be it father or mother- as there may be incongruences in the eyes of Japanese law between their sex in the koseki, their gender identity, their reproductive capacity and their marital status.

## **2.2. Healthcare and general health**

When talking about health as relating to human rights, it should be noted that, as explained by the ESCR Committee,

The right to health is not to be understood as a right to be healthy (as it) contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health. (as cited in Amnesty International, 2016)

Therefore, the SRS requirement breaches trans people's reproductive rights as well as their right to integrity and to private family life while also taking away their right to enjoy the highest attainable level of health (Amnesty International, 2016) (Gay Japan News, 2013) given that said requirement is put in place for reasons other than the treatment of trans patients' gender dysphoria, as has been argued throughout this thesis. Moreover, apart from the issues mentioned in sections 1.2.2, 1.1.3 and 1.1.4, there are other instances where the right to quality treatment and equal access to health care is also breached. As the “*majority of medical professionals lack sufficient knowledge and*

*basic terminology of LGBT issues” they may often make “discriminatory remarks without noticing” and LGBT patients will “often feel unable to disclose their sexual orientation or gender identity because they do not trust their sexuality will be understood or accepted” when seeking mental health care or other medical services (Amnesty International, 2016). Moreover, and as was briefly mentioned in section 1.1.3, transgender patients may have trouble accessing and getting proper treatment when their gender presentation doesn’t match with either their reproductive organs or their sex in the koseki, given that,*

Since most important official documents including the residency certificate and public insurance card are issued based on the family registry, transgender persons often face difficulties accessing health care with their insurance card on which their legal gender and actual gender seemingly do not match. (Gay Japan News, 2013)

Lastly, it should also be noted that *“the suicide rate among LGBT people in Japan which is higher than average is seen as the most pressing problem by organizations supporting LGBT rights as according to them it is seen as a matter concerning the right to life” (Amnesty International, 2016).*

### **2.3. Employment and workplace**

There is no legislation in Japan which explicitly prohibits employment and workplace discrimination on the basis of sexual orientation or gender identity (“LGBT Rights in Japan,” n.d.) (Amnesty International, 2016)(Gay Japan News, 2013)(Stonewall Japan, 2016), which in some cases can lead to transgender people being fired or discriminated against through instances such as not being able to use the bathroom, changing room or uniform matching their gender identity or being explicitly asked to change their gender presentation in the workplace (Gay Japan News, 2013). In this way, it is common for LGBT individuals to hide their sexual orientation or gender identity *“due to a fear of losing (their) job or facing discrimination” (Amnesty International, 2016).* Moreover, *“job applications are particularly challenging for transgender individuals if their gender does not match the gender (on) their identification document” (Amnesty International, 2016).* Other instances where transgender workers may feel threatened or unsafe due to their gender identity are company health check-ups, as they feel that in those occasions their gender identity may attract attention, with cases where trans workers have been outed to their colleagues during the process (Amnesty International, 2016). As such, all of the aforementioned instances breach the human right to work, free choice of employment and just and favourable conditions of work as well as protection against unemployment (UN General Assembly, 1948).

### **2.4. Prison system and detention facilities**

When being held in detention, *“LGBT people (...) are frequently at particular risk of violence, harassment and abuse – both from officials such as police and prison guards and other inmates”*

being transgender individuals especially vulnerable, as they are “*routinely subjected to a host of abusive practices*” and suffer “*double or triple discrimination*” compared to other inmates (Amnesty International, 2016). In this way, the right preventing people from being “*subjected to torture or to cruel, inhuman or degrading treatment or punishment*” (UN General Assembly, 1948) is often breached. Moreover, if a transgender person has not undergone the legal process to change the gender marker in their *koseki*, their detention center -either male or female- will be chosen according to the sex stated in their *koseki* regardless of whether they have undergone any kind of gender transition and of their gender presentation, which can often lead to instances of abuse and discrimination (Amnesty International, 2016). It is also not rare for transgender inmates to not be allowed to continue hormonal treatment during their imprisonment regardless of the serious negative consequences this can have for both their mental and their physical health, as HRT is “*beyond what is considered “treatment for disease” which is required by law to be provided in detention*” (Amnesty International, 2016).

## **2.5. Other instances**

Apart from the aforementioned issues when searching for a job or trying to obtain medical treatment, a transgender person’s identity not matching their legal documents can lead to discrimination in other instances such as when looking for adequate housing (Gay Japan News, 2013). Moreover, in the event of a natural disaster, “*transgender people face problems such as accessing temporary public toilets, showers and gender-specific relief supplies such as sanitary products and underwear*”. Even “*simply requesting access to facilities and supplies can be challenging for (transgender people) because it means disclosing their gender identity*” or their transgender status (Amnesty International, 2016).

Lastly, given the high rate of school refusal in transgender children and adolescents (Terada et al., 2012b), their right to education cannot always be ensured, and LGBT students may be subjected to violence in school given that they are “*among the most vulnerable to bullying*” (“Japan: HRW - LGBT Students Unprotected in Japan,” 2016). Moreover, school refusal is associated to other negative factors such as psychiatric comorbidity being present “*significantly more often in GID persons who refused to attend school than in those who did not*” (Terada et al., 2012). Other issues affecting transgender people’s health are linked to different variables, such as “*poor communication skills, mental disability, domestic violence, poverty (and) having no parents to rely on*” (Amnesty International, 2016).

### 3. CONCLUSIONS AND FINAL SUGGESTIONS

Despite the 2003 Act being presented as a progressive legislation aiming for the better inclusion of transgender people in Japanese society, the misconception of transgender identity it is based on which equates being transgender with a disorder or disability and understands trans individuals as striving to meet socially accepted standards of cisheteronormativity means that there are still many barriers to be overcome before transgender people can enjoy their lives as full right Japanese citizens. While the existence of a legal process allowing transgender citizens to change their name and sex marker is a step in the right direction, a long way still remains for equality to be achieved. As such, the last section of this thesis will focus on summarizing the main issues presented throughout this thesis by providing a general list of suggestions on how the current situation of transgender people could be improved through institutional action.

First of all, a modification of the 2003 Act and the conditions limiting the access to the change of legal documents -the *koseki*, in this case- should be considered. A legislation that better matches the latest version of the DSM and the guidelines provided by the WPATH and which has transgender people's best interest in mind would facilitate integration and make legal processes less lengthy and complex, as many of the conditions included in the 2003 Act such as the need for surgery and forceful sterilization -sections IV and V- and not having minor children -section III- could be removed, given that they do not make sense according to the latest research nor according to medical standards for the care of transgender patients. By either eliminating or reformulating sections I to V, many of the human rights violations coming from the 2003 Act could also be solved, given that transgender people could be handed back agency over their bodies and their reproductive choices, be given the right to form their own families in their own terms and gain overall better control over their lives and medical choices through the minimization of state interference in the private sphere of their lives. In this way, and also observing the recommendations of the DSM and the WPATH, Japanese health and medical institutions should aim for the de-pathologization of the transgender community by officially removing the GID (性同一性障害) nomenclature from their care guidelines in order to facilitate a transition from a very medicalized, othering perspective of transgender identities to a more inclusive and normalized understanding of transgender individuals. De-pathologization would also aid in generalising a socially shared view of transgender people as equal, capable members of society and thus would deem sections of the 2003 Act such as article 2 and section III unnecessary or simply unreasonable. Moreover, as equality between cisgender and transgender folk is pursued, other incongruences such as the differences in health care coverage by national insurance could be tackled by, for example, extending hormone therapy coverage to HRT. This would also aid in eliminating economic class as a variable when it comes to accessing medical transition.

Secondly, and in order to improve health care and quality of life for trans people, access and quality of information before, during and after transition should also be improved. Transgender people

should be aware of all of their options when it comes to medical transition so they can make informed decisions which target their personal needs and allow them to have a smoother transition socially, personally and also medically if desired. Some examples would be making sure that patients understand that medical transition is an optional, personal choice that should be focused on each person's individual needs; routinely informing trans patients of reproductive options such as fertility preservation pre HRT or SRS; addressing common misconceptions such as that of testosterone acting as a contraceptive; etc. Moreover, if the existence of a predetermined, standardized line of treatment for all transgender patients is eliminated, the increased freedom within physical transition and gender exploration could translate into a progressively less stigmatized view of gender variance thus helping to create a less dichotomous, restrictive view of gender both within transgender communities and society at large, which would aid in the generalization of a broader, more inclusive definition of gender and the de-stigmatization of non-cisheteronormative identities. In this same way, information on transgender issues and a general understanding of transgender identity to third parties such as general care doctors, psychologists and psychiatrists and medical staff in general, as well as government officials and other professionals who may have to interact with transgender people in their jobs such as teachers should also be considered in order to create a safer environment for transgender individuals to explore their gender, "come out" and transition without fear of judgement or discrimination. Medical staff being aware of the existence of transgender people, the existence of non-cisnormative bodies and how to adequately treat and interact with transgender patients would also improve the quality of healthcare for transgender patients and help to ensure that they can enjoy the highest standards of medical treatment and get adequate care, as was mentioned should be their right in section 2.2. Additionally, the inclusion of non-heteronormative families in the Japanese family system should also be considered given that it would allow transgender people freedom of marriage and reproduction while also improving the lives of LGBT people at large. It should be kept in mind that marriage and other ways of official partnership not only hold sentimental value and social significance but also come with a set of rights, duties and legal specifications that can be essential for many couples in daily life and other instances, as was explained in section 2.1. Making same-sex marriage legal would also be a step towards giving transgender people back their right to family.

Lastly, protective laws for LGBT people in areas such as employment discrimination and workplace harassment, housing discrimination and educational issues such as bullying should be put in place in order to secure transgender folk against abuse and discrimination. Laws that criminalise hate and discrimination towards sexual minorities and promote the safety and inclusion of LGBT people are essential in order to move towards a more accepting and respectful society given that, even though said laws do not bring immediate change, they can help create awareness of the situation of minorities and are also a resource for LGBT people to access when they are faced with instances of abuse and/or discrimination and which provide them with institutional backup and protective legal tools.



As conclusion to this analysis, it should also be remembered that many of the issues presented throughout this thesis are not exclusive to Japan; transgender people suffer from discrimination all over the world and trans rights have come to the front lines of the human rights movement in the last decades. Institutional support to transgender lives can be immensely significant and influence slow but long lasting change in society, and is also an essential part of the process for equality pursued by the LGBT community at large. Case studies like the one conducted in this thesis can help shed some light on the legal, medical, social and personal issues that transgender people face in their daily lives and that keep them from being full right citizens of their respective countries, even if it may seem that they hold every right, just as cisgender folk do, on paper. Furthermore, it should also be remembered that the degree of discrimination and abuse suffered by transgender people is irrevocably linked to other aspects of their lives as well such as their race, socio-economic class, sexual orientation, etc., which opens the door to possible case studies that take into account the intersectional aspect of transgender discrimination, which is still largely unexplored in Japan. While the study conducted in this thesis is very focused on specific aspects of the transgender community in Japan and how it is affected by the current legislation, other equally important aspects were left out in order to provide a clearly focused analysis and also due to a lack of space and resources. However, the existence of other transgender narratives and spaces such as transgender people working in the entertainment industry, transgender sex workers, transgender people working in “night life” spaces, etc., together with the aforementioned intersectional variables, should also be considered when assessing other significant areas of the situation of transgender people in Japan in the future.

## 4. GLOSSARY

**Cisgender:** Person who identifies with the gender that was assigned to them at birth; opposite of “transgender”.

**Cisnormative:** Taking cisgender as the norm; understanding being cisgender as “normal” as opposed to other gender identities.

**Gender binary:** Binary gender system where gender is understood as a dichotomous category within which a person can only either be male or female.

### **Gender dysphoria:**

Gender dysphoria involves a conflict between a person's physical or assigned gender and the gender with which (...) they identify. People with gender dysphoria may be very uncomfortable with the gender they were assigned, sometimes described as being uncomfortable with their body (particularly developments during puberty) or being uncomfortable with the expected roles of their assigned gender.

People with gender dysphoria may often experience significant distress and/or problems functioning associated with this conflict between the way they feel and think of themselves (referred to as experienced or expressed gender) and their physical or assigned gender. (“What Is Gender Dysphoria?,” 2016)

**Gender identity:** *“Refers to a person’s deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body”* (Amnesty International, 2016).

**Gender presentation:** Outward appearance of a person as relating to how they present and express their gender identity to other people and themselves. For example, a transgender man may choose to portray a more masculine gender presentation -wear typically masculine clothing, short hair, flat chest, etc.- while another transgender man, while still identifying as a man, may have a more androgynous or even feminine gender presentation -wearing typically feminine clothing such as skirts, using cosmetic products such as nail polish or makeup, or simply choosing to decline medical treatments typically used for alleviating gender dysphoria in transgender men such as HRT or mastectomy. It should also be noted that some transgender folk may not understand their gender presentation as masculine, feminine or androgynous but rather just as the kind of gender presentation that makes them feel comfortable and at ease with themselves.

**Gender nonconforming:** Individual, either transgender or cisgender, that doesn't adhere to mainstream gender roles, norms or presentation "*in a given culture and historical period*" (The World Professional Association for Transgender Health, 2011) . For example, a butch lesbian woman -either cisgender or transgender- may be described as gender non-conforming, as her gender presentation doesn't match what is typically considered feminine.

**Heteronormative:** Taking heterosexuality as the norm; understanding being heterosexual as "normal" as opposed to other sexual orientations.

**Passing:** Used to refer to transgender people that "pass" as cisgender, namely who are assumed to be cisgender in accordance to their physical appearance, demeanor, etc. This is a very controversial term that many transgender people reject given that the goal of gender transition shouldn't be that of meeting cisgender beauty standards or "appear cisgender" but to feel comfortable in one's own body and gender presentation.

**Transfeminine:** Individual who transitions from a typically masculine gender presentation to a more typically feminine one. Commonly used to refer to transgender women or AMAB (Assigned Male At Birth) trans people.

**Transmasculine:** Individual who transitions from a typically feminine gender presentation to a more typically masculine one. Commonly used to refer to transgender men or AFAB (Assigned Female At Birth) trans people.

**Transition:**

Period of time when individuals change from the gender role associated with their sex assigned at birth to a different gender role. For many people, this involves learning how to live socially in "the other" gender role; for others this means finding a gender role and expression that is most comfortable for them. Transition may or may not include feminization or masculinization of the body through hormones or other medical procedures. The nature and duration of transition is variable and individualized. (The World Professional Association for Transgender Health, 2011)

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## 6. APPENDIX

(Extracted from: Act on Special Cases in Handling Gender for People with Gender Identity Disorder (Japan) Law No. 111 of 2003 (Effective Jul. 16, 2004). (2013). *Asian-Pacific Law & Policy Journal*, 14(1), 203–204.)

### **Act on Special Cases in Handling Gender for People with Gender Identity Disorder (Japan) Law No. 111 of 2003 (Effective Jul. 16, 2004)**

*Translation by Chiaki Ota*

#### ARTICLE 1: PURPOSE

This Act provides the statutory handling of special cases for people with Gender Identity Disorder.

#### ARTICLE 2: DEFINITION

In this Act, “Gender Identity Disorder” means a person, despite his/her biological sex being clear, who continually maintains a psychological identity with an alternative gender (hereinafter, “alternative gender”), who holds the intention to physically and socially conform to an alternative gender, and who has been medically diagnosed in such respects by two or more physicians generally recognized as holding competent knowledge and experience necessary for the task.

#### ARTICLE 3: PROCEDURE TO CHANGE THE TREATMENT OF GENDER

1. The Family Courts are authorized to adjudicate a change in the handling of gender upon the application of a person with Gender Identity Disorder who fulfills the following requirements:

- i. The person is 20 years or older;
- ii. The person is not presently married;
- iii. The person does not presently have a minor child;
- iv. The person does not have gonads or permanently lacks functioning gonads; and
- v. The person’s physical form is endowed with genitalia that closely resemble the physical form of an alternative gender.

2. In making an application as provided for in the previous section, an applicant must submit medical certification indicating the applicant’s status as a person diagnosed with Gender Identity Disorder as provided for in Article 2 above and other matters as may be provided for by Ordinance

of the Ministry of Health, Labour, and Welfare, including but not limited to the progress or results of any medical treatments.

**ARTICLE 4: STATUTORY HANDLING OF PEOPLE ADJUDICATED TO HAVE CHANGED THEIR GENDER**

1. People who are adjudicated to have changed their gender, except as may be specifically provided otherwise in the laws, are regarded as having changed to an alternative gender in the application of the Civil Code (Law No. 89 of 1896) and all other laws and regulations.

2. Except as may be specifically provided otherwise in the laws, the provisions in the previous section shall not affect personal status and/or any rights and obligations arising prior to the adjudication of having changed one's gender.

**ARTICLE 5: APPLICATION OF DOMESTIC RELATIONS TRIAL ACT**

In the application of the Domestic Relations Trial Act (Law No. 152 of 1947), the adjudication of a person's change in gender is regarded as a listed matter included in Article 9, Section 1 thereof.

**SUPPLEMENTAL PROVISION (EXCERPTED)**

*Effective Date*

This law will come into effect one year after the date of its promulgation (July 16, 2004).